Strategic Planning FY 2020–2022

Behavioral Health

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COOK COUNTY HEALTH

CCH Vision 2015

A Comprehensive Behavioral Health Network

Develop a continuum of care across the current health system and other partners that expands access and fills current gaps

Build shared operations and infrastructure that will enable the BH Network to effectively manage services that will improve population health, and health outcomes

Support the ability of partners to improve quality of services offered and strengthen the system of care, reducing use of inpatient, emergency department, and correctional beds

Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- Impact Social Determinants
- Advocate for patients

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Impact 2020

Progress and Updates

Focus Area	Name	Status
Deliver High Quality Care	CCH Department of Psychiatry to resume consulting services in the Emergency Room	Complete • Hired CCH employees to staff ED
Deliver High Quality Care	Explore opportunities to reduce the jail population	Ongoing • Opened two Triage Centers • Vivitrol and Naloxone programs at the Jail
Grow to Serve and Compete	Work with local, state and federal stakeholders to streamline the care transition process for justice-involved populations to prevent gaps in care	Ongoing • Support collaborations for linkages of care/Care Coordination at both JDTC/CERMAK

Impact 2020

Progress and Updates

Focus Area	Name	Status
Grow to Serve & Compete	Behavioral Health Consortium to support Transition of Care to fill gaps in care as continuum of BH services across CCH Provide wrap-around services for vulnerable patients-uninsured, SMI, etc.	Ongoing
Foster Fiscal Stewardship	Implement full billing for behavioral health	Ongoing • LCSW to begin billing for services
Deliver High Quality Care	Integrate and expand additional services, especially in outpatient health centers including behavioral health (mental health and substance abuse)	In progress • Addition of psychiatrist to all Ambulatory Clinics for 1-day /week something we have done • LCSW case managers will be assigned to cover regional areas

Impact 2020

Progress and Updates

Focus Area	Name	Status
Deliver High Quality Care	Establish an integrated continuum of behavioral health services throughout CCH, including CountyCare	In progress • Transition of Care collaborations • Behavioral Health Consortium • Care coordination for Behavioral Health needs across CCH
Deliver High Quality Care	Integrate behavioral health practice management tools within the electronic medical record	In progress • Templates to be used for consistent documentation • Streamline screening tools to reduce redundancy of information collection.
Leverage Valuable Assets PCP-BH Integration	Phase 1&2 Initiation of staff and resources; conceptual planning with some implementation.	Complete • Phase 1, Initiation • Phase 2, Planning In progress • Phase 3, Implementation

FY2020–2022

The Future

Environmental Scan of Market, Best Practices and Trends

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CCH Vision

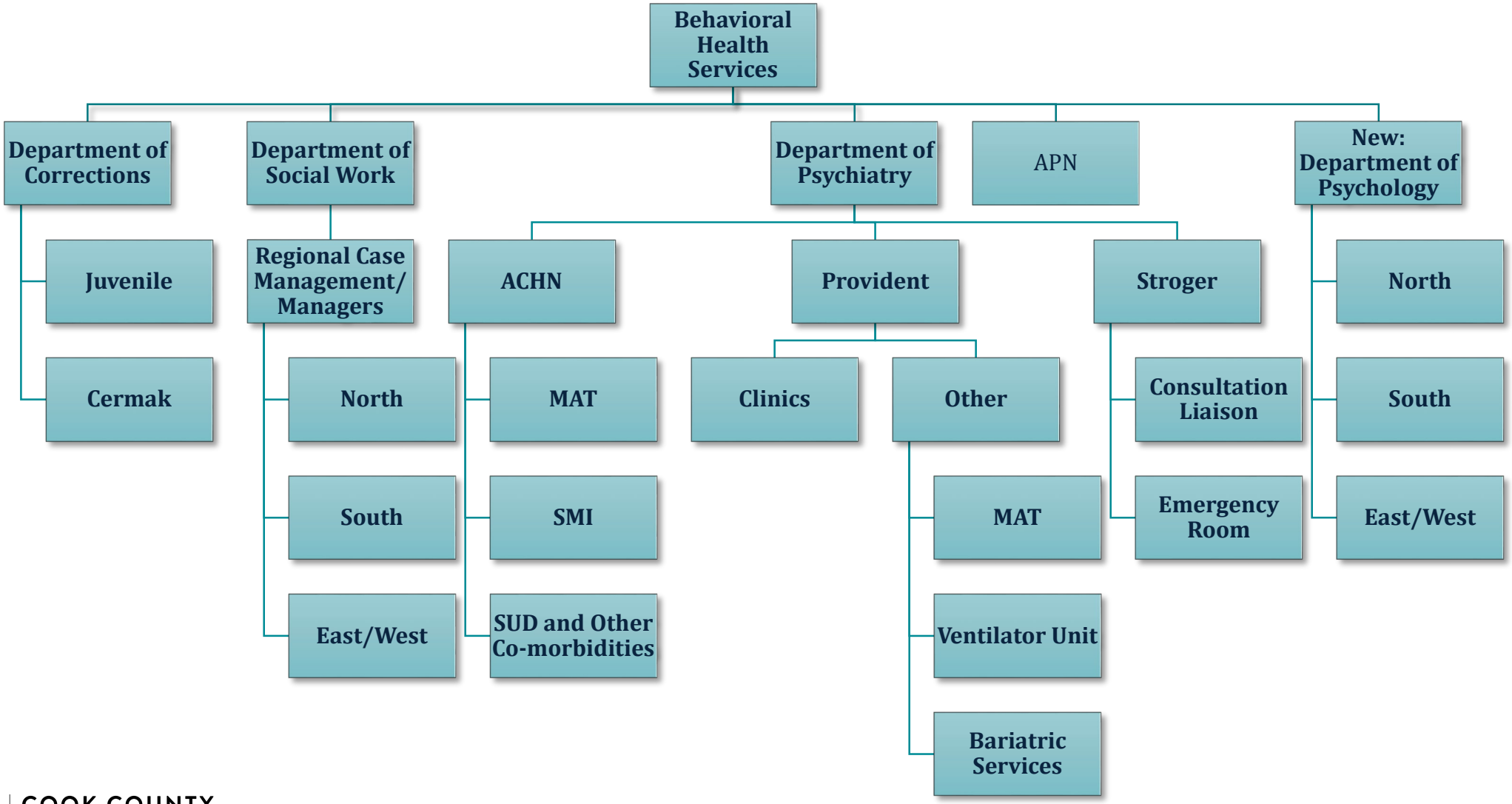
A Comprehensive Behavioral Health Network

Lead the continuum of BH services across CCH with focus on the most vulnerable patients where collaboration with other partners (internal/external) are paramount to increase access to care, fill gaps & improve health

Build a more solid Infrastructure to enable BH Network expansion and synergize shared operations to improve access, wrap around services, address homelessness, health + patient experience

Identify the capabilities of providers & partners to improve access, quality, value, and fiscal responsibilities to strengthen care across CCH by reducing wait lists, no show rates, hospital beds, ED visits

Behavioral Health Services at CCH



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Environmental Scan of Market, Best Practices, Trends

Innovative tools required to support our current business trend by providing value

Tele-psychiatry

More than 80 million millennials will comprise a larger pool of behavioral health. Treatment centers will need to shift to appeal to this digitally connected population

- Tele-psychiatry as a tool to increase access to care, delivery of real-time services, fast and efficient which decreases waiting lists and no-show rates, ultimately increase provider productivity and improved quality care.
- In Ambulatory clinics
- In Corrections –Juvenile Treatment Detention Center (JDTC) and Cermak Health
- In Behavioral Health Consortium (BHC) agencies
- In Stroger Hospital
- Cerner tele-psychiatry platform build is required to support services across of CCH plus information sharing rights and template building tools for documentation of services, scheduling, staffing as well as the continual management.

Environmental Scan of Market, Best Practices, Trends

Innovative tools required to support our current business trend by providing value

Addiction Medicine

- Addiction Treatment ("Opioid Crisis")
- Addiction Medicine - Partnering Program at CCH
- Leverage internal expertise and build-in external expertise where needed
- Expand partnerships to support and collaborate on specific care and redundancy of addiction services. Examples include:
  - University of Illinois
  - RUSH
  - Mount Sinai
- Leverage grant opportunities to support:
  - infrastructure program build
  - training/education
  - other ancillary services (wrap-around services)
- Develop a formal Medication Assisted Treatment with full Level 1, 2, & 3 interventions
- Develop construct of Centers of Excellence in Addictions through partnership engagements

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats

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SWOT Analysis

Strengths
- Excellent model for primary care provider-behavioral health integration
- Model for integration continues to grow
- Model is the national and global best practice for the future of Behavioral Health delivery
- Strong Grants Research & Development-dedicated partners
- Good internal stakeholders collaborations: CountyCare & Integrated Health, Ambulatory

Weaknesses
- Current Behavioral Health Services across CCH lack a cohesive structure for consistency of patient care
- Lack of tools, billing, IT templates, workflows/plans, algorithms, and Standard Operating Procedures to support expanded CCH business
- Thin infrastructure development to support full MAT (behavioral interventions) certified treatment programs

Opportunities
- Build Tele-psychiatry/Telehealth services across CCH for innovative way to provide real-time BH
- Build infrastructure to support expansion of Medication Assisted Treatment by evaluating customer needs and outcomes parameters
- Leverage grants/initiatives to support key objectives for building MAT infrastructure, improve homelessness, promote sustainability of efforts

Threats
- Weakly defined roles and responsibilities lead to lack of continuity of care
- Understanding of impact of productivity on finances and billing/fiscal stewardship
- Understanding the role of value in our service delivery

FY2020–2022

Innovation is the Future of Behavioral Health

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Illinois Behavioral Health Transformation

Department of Health and Family Services

Section 1115 Demonstration waiver proposed critical next steps:

Goals:

1. Rebalance the behavioral health ecosystem, reducing over-reliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in/Partner to attain support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

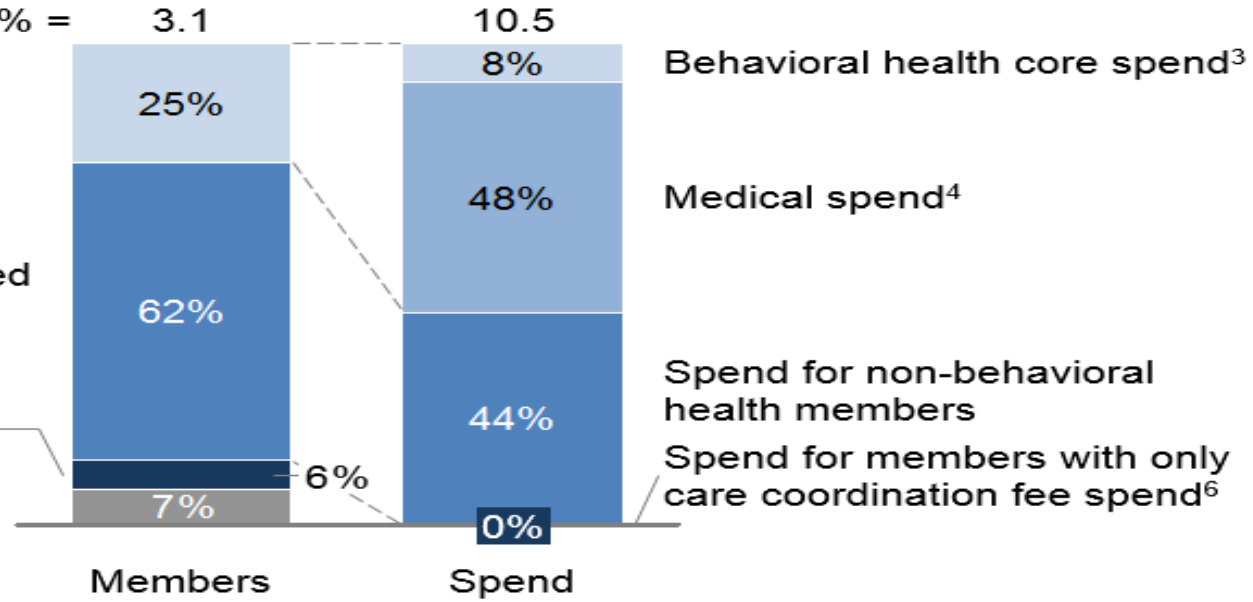
CCH systems and strategies closely align to these State goals

Illinois Behavioral Health Transformation 2015

Medicaid members with diagnosed and/or treated behavioral health needs make up 25% of the population, but 56% of the total spend

FY2015 members and spend[1,2]

Annualized members (millions), dollars (billions)



1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12
2 Most inclusive definition of behavioral health population used here of members who are diagnosed and treated, diagnosed but not treated, and treated but no diagnosis present. Behavioral health core spend defined as all spend with a behavioral health primary diagnosis or behavioral health-specific procedure, revenue, or HIC3 pharmacy code.
3 Behavioral health core spend is defined as spend on behavioral health care for individuals with behavioral health needs
4 Medical spend is defined as all other spend for individuals with behavioral health needs. See appendix for additional methodology notes
5 Behavioral health diagnosis is defined as a behavioral health diagnosis in any of the first 18 diagnosis fields of any claim during the year. Behavioral health treatment is identified on the basis of a claim with a behavioral health primary diagnosis or a behavioral health-specific procedure, revenue, of HIC3 drug code during the year
6 Annualized members with only spend for care coordination fees. Care coordination fee is identified by HCPCS codes - G9002, G9008

SOURCE: FY15 State of Illinois DHFS claims data

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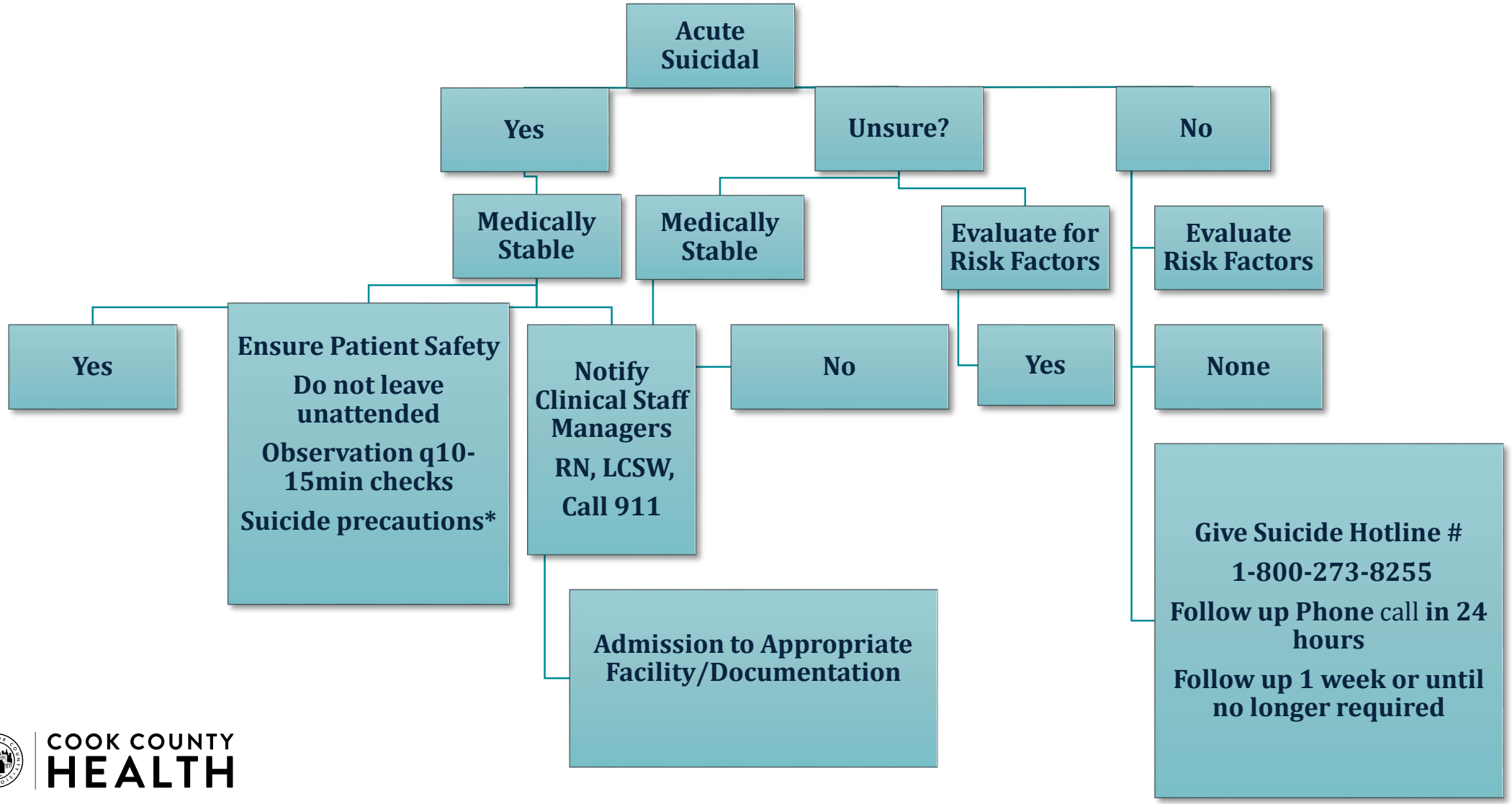
Deliver High Quality Care
FY 2020–2022 Strategic Planning Recommendations
Primary Care Physician and Behavioral Health Integration

- Phase 1 and 2 are complete
- Phase 3 requires developing infrastructure to solidify operations: identify barriers, define provider roles and responsibilities, develop tools to support workflow, algorithms and build consistency across all ambulatory health centers, implement a culture of collaboration, identify best practices, institute training programs, resolve State policies that hinder reimbursement, consider other value added resources of Family/Marital Counseling to support areas that require more intensive therapies, form multidisciplinary team approach to shared-care responsibility model
- Phase 4 requires testing and monitoring processes put in place and analyzing data, outcomes, identify value added services and HEDIS (Health Effectiveness Data and Information Set) measures, fill gaps in delivery of care, workflow obstacles-test and continue tracking and trending data
- Phase 5 -Full integration- Barriers resolution, gaps filled, measures support improved patient outcomes, increase patient access to care, increased provider productivity, reduce reimbursement issues, improve quality/value added services

Consistent Patient Care Processes -- Suicidal Ideation Example
Acutely Suicidal Algorithm Draft



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Deliver High Quality Care
FY 2020–2022 Strategic Planning Recommendations

PCP and BH Integration – Medication Assisted Treatment

- Expand Medication Assisted Treatment into a comprehensive substance abuse program with integral Behavioral Health Services to support opioid treatment :Level 1, 2, & 3. as well as other substance use disorders (SUD)/Severely Mentally Ill (SMI) patient care.

Potential Centers to be designated as Centers of Excellence:

- **Prieto**- Currently provides Alcohol, Opioid, and Smoking cessation services
- **Austin**-Currently has comprehensive structure that can be leveraged to provide and even greater continuum service with Psychiatry and Westside Community Triage Centers for (Substance Use Disorders)
- **CORE**-Currently has an excellent delivery of care via case coordination of services for HIV, and Substance Use Disorders-most comprehensive model of care

PC–BH Integration Implementation Status and Successes

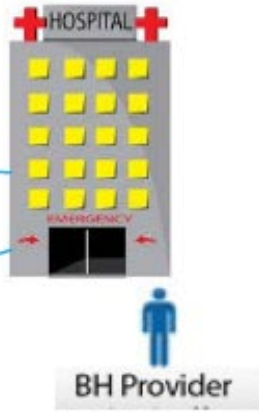
Grow to Serve and Compete
FY 2020–2022 Strategic Planning Recommendations

Behavioral Health Consortium

12 member-based organization originally identified in 2015 to augment CCH community Behavioral Health services

- Improve capacity to support CCH business
- Identify strengths and weaknesses of each Behavioral Health Consortium member
- Enhancement tools to measure quality and data analysis to transition of care
- Patients lost to follow up, delivery of care to the uninsured, patient experience etc.
- Optimize BHC services to support CCH expenditures by evaluating operations and processes to identify gaps, billing, redundancies/duplication scope of work, enhancement of cost cutting measures, justification and reconciliation
- Quarterly meetings to provide data analysis (HEDIS + others parameters) to each member to evaluate and monitor deliverables

Behavioral Health Consortium



CCHHS Behavioral Health Continuum of Services

Foster Fiscal Stewardship
FY 2020–2022 Strategic Planning Recommendations

Dept. of Psychiatry, Dept. of Social Work, Behavioral Health Consortium, Community Triage Centers

- **Improve Access**: Add providers to specific sites to assist with immediate need, decrease waiting list/ backlog, build in efficiency tools: Regularly scheduled structured groups, tele-psychiatry/health, mobile crisis units
- **Improve Quality**: Provide oversight for each Behavioral Health Consortium member and evaluate each member capabilities or capacity to support the current and future needs of CCH + CountyCare business with concrete metrics to support
  - Current deep dive and monitoring of each member capabilities and analysis of fiscal yield per each member, adding more concrete parameters (Health Effectiveness Data and Information Set) HEDIS measures) to evaluate performance
- **Increase Provider Productivity**: Set expectation of daily volume of patient visits, offset no show rates and scheduling services to support this rate, decrease wait lists/backlog
  - Decrease redundancies for delivery of services, support consistency via workflows, algorithms, templates. processes and policies
  - Reduce hours of operation costs for Community Triage Centers by developing collaborative hospital partnerships

Invest in Resources
FY 2020–2022 Strategic Planning Recommendations

Assertive Community Treatment

- Partner with Integrated Health and CountyCare, external partners
- Transition of Care
  - Tackling “Homelessness” Crisis
    - Most vulnerable: Severe Mentally Ill (SMI); SMI+SUD, MMI (Prevention)
    - Develop Community Integrated Living Arrangement (CILA) like temporary housing for up to 6 months while recovery and treatment becomes solidified
    - Implement Care Coordination Teams

  - Require wrap-around services:
    Medication Management/Medical/Nutritional Support

  - Resources needed: Care Coordinators, Community Health Workers, Health Educators, and Mental Health Workers

Leverage Valuable Assets
FY 2020–2022 Strategic Planning Recommendations

PCP/BH Integration

Expand the use of the PCP-BH model to maximize efficiencies and create best practices

- Align services to support framework of multi-discipline team huddles
- Continue to build this model with more Behavioral Health and more direct involvement of psychiatrists and regional positions of case managers (LCSW) and psychologists
- Use measurement tools to monitor and support processes that improve value, quality, patient experience, utilization of services and patient outcomes
- Build the use of telehealth/tele-psychiatry to further support the integration process
- Educational/Training programs to leverage and support expansion of this model (e.g “lunch and learn”)
- Utilize opportunities to learn from others on National & Global level how this model can supports the delivery of comprehensive BH patient care

Impact Social Determinants/Advocate for Patients FY 2020–2022 Strategic Planning Recommendations

Integrated Health, CountyCare, Collaborative Care Partners

Assertive Community Treatment (ACT)
Primary Objective: Reduce Homelessness
Requires multi-level collaboration strategies for resourcing:

- Partner with other local partners to develop and build more collaborative patient models
- Engagement of community advocacy partners
- Ensure interphases with Integrated Health, CountyCare, and ACHN sites
- Advocate for resources for the need for Community Healthcare Workers who are the direct link to continuity of care
    - Resources should be multi-factorial and spread across all partners
    - Update all intake templates to support evaluation of the social determinants and actions to be taken to assist in linkages to address these needs
    - Grants- identify those that address any elements of social determinants

CCH Behavioral Health Initiatives

AMBULATORY

- Collaborative Care Model for Medication Assisted Treatment
- Improve (infrastructure) for Expand (MAT)
- Added Recovery coaches & Psychiatrists

CARE MANAGEMENT

- Expanded CM teams to include BH expertise for TOC
- Streamline Behavioral Health Consortium services
- Behavioral Health Access Line (BHAL) valued added improvements

DEPARTMENT OF PSYCHIATRY

- Dept. of Psychiatry to provide services to all ACHN 1/day week
- Added Dept. of Psych to lead BH Education/Training
- Telepsychiatry services via IT CERNER to promote BH efficiencies, patient access and cost savings

COUNTYCARE

- Current Initiative to improve BH transitions of care process
- Integrative Management of BH services
- (HEDIS) Health effectiveness and Data Information Set and other measures to direct services

GRANT DEVELOPMENT OFFICE

- Novel Grant: BH Grant- for Children with Chronic Disease – MEND Biopsychosocial Model Loma Linda Univ.
- Grants awarded or continued in the SUD Disorders, Diversion
- Several grant applications pending worth $$$$$$$

Next Steps

Additional staff to support BH overall strategy

- Continued implementation of strategy and integration of behavioral health initiatives across CCH

Oversight, Monitoring, Implementation of Strategies to support BH

- Build infrastructure to expand Medication Assisted Treatment/addiction services
- Reframe Behavioral Health Consortium: scope of work, build hospital collaboration network, improve care coordination efforts
- Use performance indicators, quality, value-added measures, fiscal stewardship for BH programs
- Use data analysis tools to support monitoring patient care delivery and provide reports displaying tracking trends for process improvements

Continued Focus on Collaborations with CountyCare and Community Partnerships

- Improve Transitions of Care by continuing to identify and monitor the need for external resources to support expansion of this behavioral health initiative
- Juvenile Temporary Detention Center support/leverage Care Coordination services for justice-involved youth
- Evaluate partnerships for strategic implementation of BH goals
- Build incentives and leverage HEDIS/quality, value-based measures

Thank You

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